

49
8/27/02
vh

2 to cv

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

DESMOND V. GAYLE
Plaintiff,

CIVIL NO. 3:CV-01-1282

v.

(JUDGE WILLIAM W. CALDWELL)

WARDEN HOGAN and
DEPUTY BOWEN,
Defendants.

FILED

U.S. DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

AUG 22 2002

CLERK OF COURT

AFFIDAVIT OF PATRICIA L. SAUERS, M.D.

Patricia L. Sauers, M.D., being duly sworn, deposes and says:

per 9/18

My name is Patricia L. Sauers, M.D. I serve as the medical director of the York County Prison. I am licensed by the Commonwealth of Pennsylvania to practice medicine in the state of Pennsylvania. This affidavit is based upon my personal knowledge and information. I am competent to testify and would state as follows if called as a witness at trial:

1.

I am a medical doctor licensed to practice medicine in the Commonwealth of Pennsylvania.

2.

In March of 2001 and up to the present time I have been acting as the medical director of the York County Prison.

3.

Desmond V. Gayle is an INS detainee who was confined in the York County Prison in March of 2001.

4.

On admission to the, inmate Desmond V. Gayle provided transfer medical records which confirmed that he had a history of depression and schizophrenia. He had no history of gastrointestinal disease or food intolerance. On examination he was noted to be in no distress and his physical findings were normal except for slow mentation and some disorganized thoughts and confusion. He was followed by the psychiatrist during his detention at the York County Prison and was stable on Zyprexa, an anti-psychotic medication.

5.

On March 12, 2001, inmate Desmond V. Gayle was involved in an altercation. He was found to have sustained an abrasion on his upper lip but was cleared by the medical section for confinement in the BAU.

6.

While in the BAU Desmond V. Gayle filed several complaints with the medical section. The inmate presented a variety of complaints, which included abdominal pain, "feeling sick from food loaf", burning while urinating, frequent urination, difficulty in elimination and allegedly blood in his stool. (See attached medical records Exhibit "A")

7.

Inmate Desmond V. Gayle was examined each time he made a complaint, which he frequently related to consuming "food loaf".

8.

An evaluation by the medical staff indicated that there were no objective symptoms to confirm the subjective complaints made by this inmate. Urinalysis testing was normal and because of no objective findings to substantiate his complaint, he was suspected of malingering. However, he was placed on a weekly nursing sick call schedule to assure that he was not suffering from a legitimate illness.

9.

During his detention at the York County Prison, inmate Gayle was physically stable and appeared healthy on his examinations. While he complained of various symptoms, there was no evidence that he suffered any significant physical problems. Moreover, he had no problems digesting the ingredients contained in the food loaf when served to him before and after his stay in the BAU.

10.

The food loaf diet served to inmates on BAU status has been approved by a registered dietitian as an adequate source of nutrition containing the requisite calories, vitamins and food groups required to maintain good inmate health.

11.

None of the ingredients in food loaf would cause the symptoms of abdominal pain, urinary problems or rectal bleeding in a healthy inmate, and Mr. Gayle showed no evidence of being physically unhealthy either before or after eating food loaf while on BAU status.

12.

At no time was Gayle denied medical care or treatment.

13.


In my opinion, inmate Gayle suffered no adverse health consequences from eating fool loaf or being confined in the BAU.

14.

The care provided to inmate Gayle was in accord with prison regulations and within the standard of care. The inmate complaints were noted, he was examined and treated appropriately.

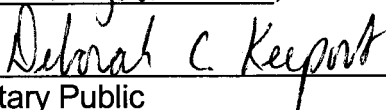
Dated: _____

8/14/02



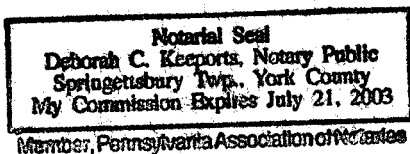
Patricia L. Sauers, M.D.

Sworn and subscribed to
Before me this 14th day
of August, 2002.



Notary Public

My Commission Expires:



A



INMATE MEDICAL REQUEST FORM

☐ DENTAL ☒ MEDICAL ☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY	PRINT ONLY	PRINT ONLY
Date: <u>MARCH/16/2001</u>	Facility/Institution: <u>YORK County PRISON</u>	
Name of Inmate: <u>DESMOND V. GAYLE</u>	D.O.B.: <u>10/10/63</u>	
I.D. # <u>55438</u>	Cell #: <u>B.A.U</u>	<u>B.A.U IEB 18</u>
Problem: (in your own words) <u>I need to see A DOCTOR, URGENTLY!</u> <u>I AM PRESENTLY in PAIN in MY ABDOMEN</u> <u>I AM PRESENTLY sick FROM the Food LOAF</u> <u>I have serious problem urinating, and when</u> <u>I do a little, it BURNS. I CAN'T STOO, I cant stool</u> <u>when I use the toilet</u>		
DO NOT WRITE BELOW THIS LINE		

STAFF SECTION

Disposition: _____

 Person Triaging: _____ Date: _____ Time: _____
 (Name)

FOR STAFF USE ONLY

S: AS ABOVE.
 O: (+) BURNING TO PENIS, (+) PAIN IN ABDOMEN, (+) PUSTULES
URINARY. (+) CONSTIPATION.
A: R/O CONSTIPATION AND UTI.P: PAIN MEDICATION, AND CALL UST.Date: 3/16/01

Health Service Signature



INMATE MEDICAL REQUEST FORM

☐ DENTAL☒ MEDICAL☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY

PRINT ONLY

PRINT ONLY

Date: MARCH 26, 2001Facility/Institution: YORK County PrisonName of Inmate: Desmond V. GayleD.O.B.: 10 10 63I.D. # 55438Cell #: BAU IEB-1B

Problem: (in your own words)

I AM sick From the Food I eat With
Stomach PAIN, Please let me see the
Doctor, I Am in Stomach PAIN now.

DO NOT WRITE BELOW THIS LINE

STAFF SECTION

Disposition: REFERRED TO CPT. KLUBERPerson Triaging: [Signature]

(Name)

Date: 3/24Time: 1948

FOR STAFF USE ONLY

S: _____

O: _____

A: _____

P: _____

Date: _____

Health Service Signature

Date/Time	Inmate Name: Gayle, Desmond	ID # 55438	D.O.B.: 1 1
3:45pm.	IM c/o burning with urination		
3/20/01	Penile discharge		
	Not drinking enough water.		
	Thinks the food loaf is causing his sxs.		
	o) Urine dip (neg)		
	Sp. grav. 1.015		
	Abdominal exam benign		
	A) Suspect malignancy (?)		
	P) ↑↑ fluids/water		
	RTC if sxs persist		
	H. Ester PAC		

Hearty

EMSA/PHS CORRECTIONAL CARE**HEALTH EVALUATION**

CHARGES

BOND:

Date: 3/15/01	I.D. #:	Date Booked:	County:
---------------	---------	--------------	---------

ADMISSION DATA

Last Name: Gough	First: Desmond	Middle:	Address:
Alias:	City:	St.:	Zip:
Birthplace:	D.O.B.:	Phone:	Religion:
SS#:	Marital Status: S M D W Sep	Read/Write English? Yes No Other:	
Previous Incarcerations (Date & Facility)		Health Insurance? Y N Carrier:	State:
Policy Number:			
NOTIFY IN EMERGENCY	Name:	Relationship:	Address:
			Phone:

MEDICAL DATA

Family Physician:	Address:	Phone:
Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where?		
See H & P <input type="checkbox"/>		
Medications: <input type="checkbox"/> None	Special Diet (Prescribed):	
Allergies: NKA <input type="checkbox"/>	Tetanus/Immunizations: Y N Dates:	

ANY ARRESTEE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING, IN ACUTE PAIN, AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE.

CLINICAL OBSERVATIONS

1) Level of Consciousness: () Alert () Oriented, time, place, person () Lethargic () Stuporous () Comatose Describe:	3) Substance Abuse: () Yes () No () Suspected () Current Intoxication/Abuse () Use () Withdrawal Symptoms () Drugs () Alcohol Describe: What kind? Amount/Frequency? Last Use: (Time/Date)
2) General Appearance: () Norm () Abn. Describe:	4b) Affect/Mood: () Normal () Manic () Depressed () Euphoria () Flat () Confused () Delusion () Emotional Instability () Hallucinations () Hearing Voices () Mental Retardation Describe:
4a) Behavior/Conduct: () Calm () Cooperative () Non-Violent () Agitated () Uncooperative () Violent () Manipulative () Disorganized Describe:	5b) Does Pt. Describe Suicidal Thoughts or Ideations? () Yes () No
5a) Is Patient at High Risk for Suicide? () Yes () No	d) High Risk Pt. may become Assaultive towards Staff? () Yes () No
c) Is there evidence of Self Mutilation () Yes () No	
e) Is there a history of a violent offense? () Yes () No Sexual offense? () Yes () No	
If ANY of the above in #5 are circled, staff MUST describe here, include previous dates:	
6a) Communication Difficulties () Yes () No	b) Memory Defects () Yes () No
c) Hearing Impairment () Yes () No	d) Speech Difficulties () Yes () No
7) Physical Aids: () None () Glasses () Contacts () Hearing Aid () Dentures () Cane () Crutches () Walker () Wheelchair () Braces () Artificial Limb () Other	
8) A/Comments, Complaints, Symptoms: None <input type="checkbox"/>	
S)	
O)	
A)	
P)	

MAR 01

**EMSA CORRECTIONAL
CARE**

I have a permanent
birth problem
need Double Tiolet
papers weekly

I have Address this matter six
months ago and I am doing it again
To the highest level
of Authority!

INMATE MEDICAL REQUEST FORM☐ DENTAL☒ MEDICAL☐ MENTAL HEALTH

(Please check one of the above)

I need to see the Doctor

PRINT ONLY**PRINT ONLY****PRINT ONLY**Date: MARCH 8, 2001Facility/Institution: York County PrisonName of Inmate: DESMOND V. GAYLED.O.B.: OCT 10, 63I.D. # 55438Cell #: NSD 11-B

Problem: (in your own words)

I WANT to see the Doctor about obtaining
A Double Portion of Weekly Issues Tiolet papers
I WAS born with excessive Attendance of
Bowel Removements not many inmates have this
type of Problem

DO NOT WRITE BELOW THIS LINE

I have to trade my
Food sometime for
Tiolet papers

STAFF SECTION

Disposition: _____

Person Triaging: _____ Date: _____ Time: _____

(Name)

FOR STAFF USE ONLY

S: _____

O: _____

A: _____

P: Request deniedDate: 3/9/01

Health Service Signature



INMATE MEDICAL REQUEST FORM

☐ DENTAL☒ MEDICAL☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY

PRINT ONLY

PRINT ONLY

Date: APRIL 20th 2001 Facility/Institution: YORK County Prison
 Name of Inmate: DESMOND Gayle D.O.B.: 10/10/63
 I.D. # 55438 Cell #: 1A-13A

Problem: (in your own words)

My finger NAILS are overgrown,
And they ARE cutting me, I need to
Cut my NAILS, thank you.

DO NOT WRITE BELOW THIS LINE

STAFF SECTION

Disposition: ALLOW him TO CUT NAILSPerson Triaging: Ry

(Name)

Date: 4/27/01Time: 1344

FOR STAFF USE ONLY

S: _____

O: _____

A: _____

P: _____

Date: _____

Health Service Signature

EMSA CORRECTIONAL CARE

It's in my Medical File every "B" Prison I go, I need Bottom BUNK - BED
 I AM PRESENTLY Sleeping on the Floor, because the C/O trying to put me on Top BUNK-BED

INMATE MEDICAL REQUEST FORM

☐ DENTAL ☐ MEDICAL ☒ MENTAL HEALTH

(Please check one of the above)

To: PAT Galyger (Doctor) (Urgent Matters)

PRINT ONLY**PRINT ONLY****PRINT ONLY**Date: APRIL 15, 2001Facility/Institution: YORK COUNTY PRISONName of Inmate: DESMOND N. GAYLE D.O.B. 10/10/63I.D. # 55438Cell #: IEA - 3B-BED

Problem: (in your own words)

I have DIFFICULTIES SLEEPING!I need my Medication!Please Reinstate my Medication

(ZYPREXA) Please Remind the Medical
that I hear Voices sometimes so
I cannot sleep **DO NOT WRITE BELOW THIS LINE** on top Bunk!

STAFF SECTIONBEDDisposition: Referred for medical evaluation for better sleepPerson Triaging: Pat Galyger (Doctor)Date: 4/18/01Time: 1:00pm**FOR STAFF USE ONLY**

S: He stopped taking Zyprexa - now wishes to resume medication. Please requesting a top bunk

O: Pl - anxiety, agitated

A: Schizophrenia

P: 1) Zyprexa Restarted
2) Referred to Medical for evaluation for a top bunk.

Date: 4/18/01

Health Service Signature

Pat Galyger (Doctor)

[illegible]



INMATE MEDICAL REQUEST FORM

☐ DENTAL☒ MEDICAL☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY

Date: APRIL 4/2001

PRINT ONLY

Facility/Institution: York County Prison

PRINT ONLY

Name of Inmate: DESMOND GAYLED.O.B.: 10/10/63I.D. # 55438 (INS)Cell #: BAU FEB-1BProblem: (in your own words) INS # A74-891-110

Please Sir/Madom I Am presently feeling
A SHARP PAIN in my lower Right ABDOMEN
And attending the toilet to urinate every three =
something is wrong = minutes

STAFF SECTION

Disposition: _____

 Person Triaging: _____ Date: _____ Time: _____
 (Name)

FOR STAFF USE ONLY

S: No pain in @ lower abd. No urinary
freq & Stools looking like "string."
o: Urine dip results below. Accu 57B.
Freq. No c S/c Sleep.

A: _____

P: Nbtx @ present time.
Informed that 11M freq has c/o.

Date: 4/4/01 Bpm Tonya Cross W

MULTISTIX 10SG

NAME	_____	TECH	_____
DATE	_____		
GLUCOSE	_____		
BILIRUBIN	_____		
KETONE	_____		
SG	<u>1.020</u>		
BLOOD	_____		
PH	<u>5.0</u>		
PROTEIN	_____		
UROBILINOGEN	<u>0.2</u>		
NITRITE	_____		
LEUCOCYTES	_____		

NEW YORK COUNTY PRISON

Chart

OFFICERS DAILY REPORT

Officer's Name: Officer [illegible]Date of Incident: 8/15/01Offense or Subject Being Reported: Officer [illegible]

Offense or Subject Being Reported: Officer [illegible]

Offense or Subject Being Reported: Officer [illegible]

Date of Incident: 8/15/01Time of Incident: 145Who Involved: Officer [illegible]Where it Happened (Be Specific): NS. Rec. Room

What happened and how, if known:

(This space can be used for reporting General Daily Duties also)

Both Officer [illegible] brought to medical Officer [illegible]

Both Officer [illegible] evaluated & medical reports

(see attached) and cleared for lock up

Officer's Signature

Officer's Signature: Officer [illegible]

This report to be submitted to and commented or acted upon, by the Supervisor before forwarding to the Warden.

Supervisor's Comments: _____

This form NOT to be used for reporting incidents requiring disciplinary acts. Use the Y.C.P. form #112 "Disciplinary Report" for all known violations that may require disciplinary action.

Form #110



PROGRESS NOTES

Date/Time	Inmate Name:	ID #	D.O.B.:
3-12-01	Styke, Desmond	55438	10/10/63
7-3	S-2/p altercation		
	O-V/m presents in NAD - exclusive obvious injury - abrasion inside top lip suggestive of a tooth blunt injury. V/m C/o tenderness (R) cheekbone area but no edema w/ erythema present. ⊖ palpable tenderness. Eyes - pearl, ⊖ SOB, ⊖ CP, both hands show no signs of abrasions/bruising/deformities. A-altercation in comfort.		
	P-lip cleaned w H ₂ O ₂ , V/m cleared for lock up.		
	Maria J. Stuenkel EMB		



INMATE MEDICAL REQUEST FORM

☐ DENTAL☒ MEDICAL☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY

PRINT ONLY

PRINT ONLY

Date: June, 29, 2001Facility/Institution: YORK County PrisonName of Inmate: Desmond V. GayleD.O.B.: October, 10, 1963I.D. # 55438 I.N.S. A74-891-110 Cell #: NSB-8B

Problem: (in your own words)

A74-891-110

“
To the Medical Doctor I would like to be
tested for DIABETES. BECAUSE MY FAMILY
MOTHER AND FATHER WAS tested positive
 ”

DO NOT WRITE BELOW THIS LINE

STAFF SECTION

Disposition: _____

Person Triaging: _____

(Name)

Date: _____

Time: _____

FOR STAFF USE ONLY

S: Diabetic test. mom & Dad has it.
wants tested.O: as above.A: att. in comfort.P: Diabetic test.Date: 6/30/01 11:45A

Health Service Signature

Kulindman



IMMIGRATION & NATURALIZATION SERVICE
UNITED STATES PUBLIC HEALTH SERVICE
DIVISION OF IMMIGRATION HEALTH SERVICES



PRE AUTHORIZATION REFERRAL
OFF-SITE MEDICAL CARE

55438

Facility Name YORK County Prison Date 05/31/01
Address _____ City _____ State _____ Zip _____

Service Processing Center

Aguadilla, PR
Balavia, NY
El Centro, CA
Elizabeth, NJ
El Paso, TX
Florence, AZ
Krome, FL
Port Isabel, TX
Queens, NY
San Pedro, CA
Varick, SI, NY
Columbia Care Ctr
LA Staging

Request No

Last Name Gayle First Desmond Middle _____

Patient ID A74-891-110 DOB 10/10/63 Race X Ethnicity _____

Camp Arrival Date 5/28/99 Country of Origin Jamaica

Requested Service/Procedure Gross Debridement & Pharyng

Clinical Findings _____

heavy tartar / bleeding gums

INS Status

Court Date _____
Hearing Pending _____
FO Deportation _____
YD Pending _____
Appealing _____
Exclusion _____
Other _____

Test Results _____

Diagnosis Gingivitis

Request for Information _____

Requesting Provider Dr. C. Paluch / Dr. S. DePasqua

Phone (117) 840 7466

Referred to _____ Phone _____

Address _____ Date of Appointment _____

City _____ State _____ Zip _____ Time of Appointment _____

UTILIZATION MANAGEMENT

MCC Steven Wachu (conclusion) APPROVED DENIED PENDING

Medical Director _____ NKMP / F. J. Gayle

Reason for Denial _____

Certification No. _____ Reviewer _____ Date 6/4/01

UNITED PAYORS UP & UP UNITED PROVIDERS
AMERICA'S HEALTH PLAN

PLEASE SEND CLAIMS TO

UP&UP Health Services, Inc.
PO Box 10250
Gaithersburg, MD 20898-0250

CLAIMS & UM PHONE NUMBERS

Phone (888) 303-3922
Fax (888) 303-3957
E-Mail UP@UPUP.COM

UP & UP Health Services, Inc. 2275 Research Boulevard Rockville MD 20850-0202

COMPLETED

FILE COPY

\$65.00



INMATE MEDICAL REQUEST FORM

☒ DENTAL☐ MEDICAL☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY

PRINT ONLY

PRINT ONLY

Date: Tuesday May 29/2001 Facility/Institution: YORK County PrisonName of Inmate: Desmond V Gayle D.O.B.: 10 10 63I.D. # 55438 INS Cell #: NSB-8BProblem: (in your own words) INS # A74-891-110I need my teeth to be clean,I Am Incarcerated here for two years.Please madam! Thank you

DO NOT WRITE BELOW THIS LINE

STAFF SECTION

Disposition: _____

Person Triaging: _____ Date: _____ Time: _____
(Name)

FOR STAFF USE ONLY

S: _____

O: _____

A: _____

P: Put approval into INS for cleaningDate: 5/31/01

Health Service Signature



INMATE MEDICAL REQUEST FORM

☐ DENTAL ☐ MEDICAL ☐ MENTAL HEALTH

(Please check one of the above)

PRINT ONLY

PRINT ONLY

PRINT ONLY

Date: Friday/MAY/25/2001 Facility/Institution: York County Prison
 Name of Inmate: Desmond Gayle D.O.B.: 10/10/63
 I.D. #: 55438 Cell #: NSB-8B NSB-8B

Problem: (in your own words)

I want to see the doctor, because I kept
vomiting up the milk AFTER Breakfast in
the morning, I also having the runs to the
toilet. The milk I'm giving me stomach runs
I am not used to this 1% milk.

DO NOT WRITE BELOW THIS LINE

STAFF SECTION

Disposition: _____

Person Triaging: _____ Date: _____ Time: _____

(Name)

FOR STAFF USE ONLY

S: as above

O: _____

A: No lactose intoleranceP: diet slipDate: 5/26/01 1200 msc

Health Service Signature



DIET ORDER FORM

DATE: 5/26/01

INMATE'S NAME: Desmond Gayle

DATE OF BIRTH: 10-10-63

ID NUMBER: 55438

HOUSING UNIT: NSB

DIET ORDERED: lactose intolerant

DATE STARTED: 5/26/01 STOP DATE: LOS

SPECIAL INSTRUCTIONS:

IF ORDER WAS CALLED INTO KITCHEN, PLEASE INDICATE WHO YOU SPOKE TO:

PHYSICIAN: _____

NURSE'S SIGNATURE: 

Physician's Order

MEDIMARK® II

Form Number 2-0502

RN
RNA PHARMACY

Date

7/23/01

1120

Medication Orders

Other Orders

1	Zyprexa 10mg H.S. X 60 days
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	Desmond Gayle
16	

DNoted
7/24/01
B Anderson
(152)
hy

Noted
Howe
7/23/01
2:50 pm

RNA INCORPORATED 1986

DOCTOR

[Signature]

DIAGNOSIS

ALLERGIES

Physician's Order

MEDIMARK® II

Form Number 2-0502

RN

RNA PHARMAC

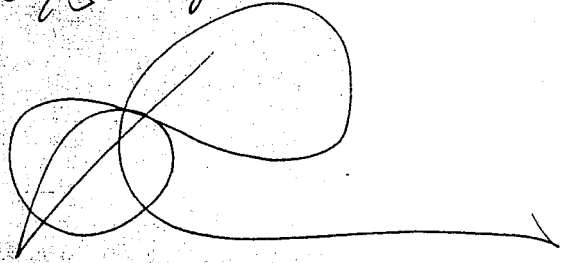
Date: 8/14/01

1140

Medication Orders

Other Orders

- 1 Zyprexa 10mg HSE - X 45 days
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15 Desmond Gayle
- 16



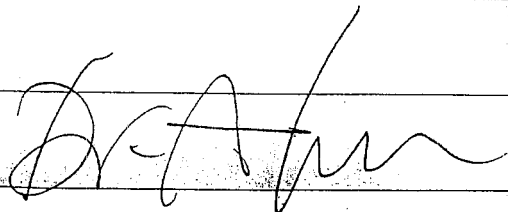
 SA

Noted
Desmond
8/14/01
2pm

double noted
medication
8-15-01

©RNA INCORPORATED 1986

DOCTOR



DIAGNOSIS

ALLERGIES

Physician's Order

MEDIMARK® II

Form Number 2-0502

RN
RNA PHARMAC

Date: 5/15/02

1505

Medication Orders

Other Orders

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16

Zyprexa 10mg. BID x 35 days

[Signature]

Bottom Zynke
to be changed if
possible

[Signature]

ASB

Desmond Boyle

Alex
Stones
5/10/02

Desmond
Boyle
5/10/02

©RNA INCORPORATED 1986

DOCTOR

DIAGNOSIS

ALLERGIES

[Signature]

EMSA CORRECTIONAL CARE

To Pat Galliger / *URGENT MATTERS*
INMATE MEDICAL REQUEST FORM

And Doctor. *AHN*

☐ DENTAL

☐ MEDICAL

☒ **MENTAL HEALTH**

(Please check one of the above)

PRINT ONLY

Date: *MAY 11/2001*

Name of Inmate: *DESMOND GAYLE*

I.D. # *55438*

PRINT ONLY

Facility/Institution: *York County Prison*

D.O.B: *10/10/63*

Cell #: *B4U-A3A*

PRINT ONLY

A Pod

Problem: (in your own words)

To Pat Galliger
Please stop the medication
until I obtained a Bottom
Bunk Bed, Because it makes me
DIZZY At Night (Lying)

DO NOT WRITE BELOW THIS LINE

Disposition: *I have problem getting up on the top Bunk*
when the medication kicking in effect.

Person Triaging: _____

(Name)

Date: _____

Time: _____

FOR STAFF USE ONLY

S: *At scales he becomes groggy about 1/2 hr*
after every medication and needs a bathroom

O: *At dinital, cooperation*

A: *Schizophrenia*

P: *1) Medical assigns bottom bunkers refuse him to speak*
when
2) Continue present medication

Date: *5/7/01*

Health Service Signature

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

DESMOND V. GAYLE
Plaintiff,

v.

WARDEN HOGAN and
DEPUTY BOWEN,
Defendants.

CIVIL NO. 3:CV-01-1282

(JUDGE WILLIAM W. CALDWELL)

CERTIFICATE OF SERVICE

I, Donald L. Reihart, Esquire, Assistant Solicitor for York County, hereby certify that a true and correct copy of the foregoing Affidavit of Patricia L. Sowers, M.D., in Support of Motion for Summary Judgment, was caused to be served on the date shown below by depositing same in the United States mail, first-class, postage prepaid, addressed as follows:

Desmond Gayle
Tangiparua Parish Prison
P.O. Box 250
Amite, LA 70422

Respectfully submitted,

By: 

Donald L. Reihart, Esq.
Sup. Ct. I.D. #07421
2600 Eastern Boulevard, Suite 204
York, PA 17402-2904
Telephone (717) 755-2799

Date: 8/21/02

Assistant Solicitor for York County